Review

Establishing a dedicated gastrointestinal bleeding centre in Chennai: Proceedings of a multidisciplinary panel conference and an evidence-aligned implementation framework with a prospective registry proforma

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Abstract

Background: Acute GI bleeding requires time-critical recognition, resuscitation, and rapid access to endoscopic and/or radiologic hemostasis. Variation in pathway execution contributes to avoidable transfusion, delayed definitive therapy, rebleeding, and mortality.

Objective: To summarize the proceedings of a Chennai panel conference convened as a prelude to launching a dedicated GI Bleed Centre, and to present an evidence-aligned implementation framework including a prospective data collection proforma for 12-month local benchmarking.

Methods: Structured meeting report with narrative evidence synthesis. Conference themes were mapped to clinical questions across five domains (front-door recognition/triage; endoscopy pathway; Intervention Radiology/surgery escalation; variceal bleeding; lower GI bleeding and systems design). Evidence mapping prioritized high-authority guidance and landmark trials, including American College of Gastroenterology- Upper Gi Bleed guideline(ACG-UGIB) (2021) , European Society Of Gastrointestinal Endoscopy- Nonvariceal Upper Gastrointestinal Bleeding(ESGE-NVUGIH) guideline (2021) , ESGE Lower GI Bleed guideline (2021) , American Association For the Study Of Liver Disease(AASLD) portal hypertension/varices practice guidance (2024) and Baveno VII consensus (2022).

Results: Proceedings emphasized a "physiology-first, pathway-driven" model: (i) Use risk scores primarily to identify very-low-risk discharge candidates; (ii) Apply restrictive transfusion as default; (iii) Perform early endoscopy within 24 hours after stabilization for non-variceal UGIB; (iv) Integrate CT- Angiography-to-Intervention

Radiology pathways for brisk bleeding; (v) Treat variceal bleeding as "double disease" requiring immediate vasoactive agents and antibiotics, and defined triggers for early Transjugular Intrahepatic Portosystemic Shunt(TIPS) in selected high-risk patients. A prospective registry proforma is provided to measure door-to-therapy times, bundle adherence, complications, rebleeding, and mortality.

Conclusion: A dedicated GI Bleed Centre can be operationalized through single-call activation, standardized checklists, 24/7 hemostasis capability and Key Performance Indicators (KPI)-driven audit, supported by prospective local data capture.

Keywords: GI bleeding; Endoscopy; CT angiography; Embolization; Variceal hemorrhage; TIPS; Bleed unit; Quality improvement registry.

1. Introduction

Acute GI bleeding remains a leading cause of emergency admission and demands coordinated multi-specialty care. High-value interventions are well described in contemporary guidelines, yet real-world outcomes are strongly influenced by system performance, especially time to activation, time to definitive hemostasis, and post-hemostasis care. Service redesign efforts, including dedicated bleed units, have reported improved outcomes in observational comparisons, and national audits continue to highlight the role of standardized care and resource availability. In this context, a single-theme panel conference was convened in Chennai to align stakeholders around a Bleed Centre operating model and to define a prospective dataset for outcome tracking.

2. Conference overview (setting, structure, aims)

The conference was held on 1 March 2026 at Hotel Green Park, Vadapalani, Chennai. The agenda comprised five moderated panel sessions (20 minutes panel + 10 minutes audience interaction), covering:

- Recognition/Triage/Resuscitation/Transfusion/Time-critical drugs
- Endoscopy timing, Checklist, Hemostasis tools, CTA-first decisions, post-endoscopy protocols
- IR initial/rescue therapies, obscure bleeding, surgical indications, antithrombotics;
- Variceal bleeding escalation including TIPS and transplant triggers
- Lower GI bleeding essentials and the Bleed Centre bundle/KPIs including ED referral networking ("golden hour") and ICU MDT care.

3. Methods

We produced a structured meeting report supplemented by narrative evidence synthesis. Panel themes were prospectively mapped to operational questions along the acute GI bleed pathway: front door → stabilization → localization → hemostasis → escalation → post-hemostasis care → discharge and follow-up. Evidence was curated from (i) Major society guidelines and consensus statements, (ii) Landmark randomized trials informing transfusion and pharmacotherapy, and (iii) System-level outcome data from bleed units and national audits. Priority sources included ACG UGIB guideline (2021),

ESGE NVUGIH (2021), ESGE LGIB (2021), AASLD portal hypertension/varices guidance (2024), Baveno VII (2022) and restrictive transfusion RCT data. The output was an implementation framework and a prospective registry proforma designed for 12-month local benchmarking prior to full centre maturity.

4. Results

Evidence-aligned pathway synthesis (organized by conference sessions)

4.1. Recognition, triage, and risk scoring

The conference emphasized early phenotype recognition and physiology-first triage. Risk scores were positioned as disposition aids for stable patients; ACG recommends ED risk assessment to identify very-low-risk UGIB patients (e.g., GBS 0–1) who may be suitable for discharge with outpatient follow-up.

4.2. Resuscitation and transfusion strategy

A restrictive transfusion approach was endorsed as default, anchored by guideline recommendations and trial evidence. ACG suggests RBC transfusion at Hb ~7 g/dL for hospitalized UGIB, and the Villanueva et al RCT demonstrated improved outcomes with restrictive vs liberal transfusion in acute UGIB. ESGE LGIB guidance provides thresholds stratified by cardiovascular disease status.

4.3. Endoscopy timing, Checklist, and Hemostasis tools

Panels aligned with ESGE recommendations supporting early endoscopy after resuscitation for NVUGIH and discouraging routine emergent endoscopy for non-variceal bleeding when outcomes are not improved. ESGE also supports combination therapy for actively bleeding ulcers (epinephrine plus a second modality) and recommends repeat endoscopy for recurrent bleeding; if the second attempt fails, Transcatheter Arterial Embolization (TAE) should be considered, with surgery reserved when TAE is unavailable or fails.

4.4. CTA-first decisions and IR integration

CTA was emphasized as a rapid localization tool in brisk bleeding and as a bridge to angiography/embolization, particularly for severe LGIB scenarios within the ESGE framework

4.5. Pharmacotherapy

Tranexamic acid was explicitly deprioritized for routine use, consistent with HALT-IT (Hemorrhage Alleviation with Tranexamic Acid-Intestinal System) showing no mortality benefit and increased adverse event signals. Variceal-suspected bleeding was framed as requiring immediate vasoactive therapy and antibiotics per portal hypertension guidance.

4.6. Variceal hemorrhage: “Double disease” and early TIPS triggers

Variceal hemorrhage was treated as bleeding plus liver failure physiology. Baveno VII provides consensus on management and supports pre-emptive TIPS within a defined window for selected high-risk patients; AASLD guidance provides a modern framework for risk stratification and acute variceal hemorrhage management.

4.7. Systems design care bundles, bleed units, and audit

The implementation approach was grounded in bundle logic: a BSG-led multisociety AUGIB care bundle was cited as a practical structure for early management standardization. Observational data from specialized bleed units show associations with lower mortality/rebleeding, and newer audit data continue to support systematic improvement opportunities.

5. Discussion

The Chennai meeting converged on a reproducible operating system: single-call activation + time-stamped pathways + 24/7 hemostasis capability + KPI governance. This is consistent with contemporary guideline thresholds (restrictive transfusion, early endoscopy post-stabilization, CTA-IR escalation, and variceal bundles with early rescue strategies) and with service-level evidence that structured bleed services can improve outcomes. The principal near-term gap is local benchmarking; therefore, the registry proforma (Supplementary Appendix A) is proposed as the measurement backbone for the first 12 months.

6. Conclusion

A dedicated GI Bleed Centre in Chennai can be operationalized through pathway standardization and measurement. The proposed registry proforma enables rapid capture of door-to-therapy times, bundle adherence, escalation decisions, complications, and outcomes—creating a local evidence base to drive iterative improvement.

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